PROVIDER REQUIREMENTS

To participate in the Home Health program, the providing agency must be Medicare-certified for Medicare/Medicaid by the Licensing and Certification Unit of the Health Standards Section of the Louisiana Department of Health. All providers enrolled in the Louisiana Medicaid program must adhere to the conditions of participation as outlined in the provider agreement.

All home health services must be provided by staff employed by or under contract with the home health agency (HHA) (see LAC 48:I, Chapter 91. Also, refer to 42 CFR 417.416 and Sec 2194 of the State Operations Manual CMS Pub. 7 for specific requirements).

All staff must meet all required licensure requirements in accordance with Medicaid policies, federal, state and other applicable laws.

Provision of Services

Home health services include medically necessary skilled nursing, rehabilitation (physical, occupational and speech therapies), home health aide, and medical supplies provided to beneficiaries only if the service is provided in the beneficiary's place of residence.

NOTE: The beneficiary's place of residence cannot be a hospital, nursing home, or an intermediate care facility for individuals with intellectual disabilities (ICF-IID, with limited exceptions), or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Electronic Visit Verification

The home health agency shall use an electronic visit verification (EVV) system for time, attendance, and billing tracking.

Home health agencies shall use the following:

1. EVV system designated by the Department; or

2. Alternate system that has successfully passed the data integration process to connect to the designated EVV system, and is approved by the Department.

Reimbursement for services may be withheld or denied a home health agency who fails to use the EVV system, or ~~uses~~does not use the system ~~not~~ in compliance with Medicaid's EVV policies and procedures for ~~EVV~~.

More resources for EVV may be found here.

Plan of Care

The authorized healthcare provider (AHP) must certify that the beneficiary meets the medical criteria to receive the service in the beneficiary's place of residence and is in need of the home health services on an intermittent basis. The AHP must order all home health services and sign a plan of care (POC) submitted by the HHA on the CMS-485 form. For more information on the Form CMS-485, visit the Centers for Medicare and Medicaid Services (CMS) website (see Appendix D). This certification and the AHP's POC must be maintained in the beneficiary's record and on file at the HHA.

Periodic Review of Plan of Care

The AHP must reauthorize the POC every 60 days.

Face-to-Face Encounter Requirements

For the initiation of home health services, a face-to-face encounter with the AHP and the beneficiary ~~and the beneficiary~~ must occur no sooner than 90 days prior to the start of home health services, or no later than 30 days after the start of home health services.

Evidence of the face-to-face encounter is required by Gainwell Technologies' Prior Authorization Unit (PAU) for routine skilled nursing and home health aide services for beneficiaries age 21 and older. If providers do not have this documentation prior to the initiation of services then the initial prior authorization (PA) request must be for 30 days only. Providers must submit documentation of the face-to-face encounter with the new PA request in order for services to be approved.

Providers should refer to **Section 23.5- Prior Authorization**, for information related to PA requirements.

For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six months prior to the start of services.

Providers should refer to **Section 23.5 Prior Authorization,** for information related to PA requirements.

Any of the following will be accepted by the PAU as evidence of a face-to-face encounter between an AHP and the beneficiary:

1. A written statement on the certifying AHP's letterhead or prescription pad attesting to a face-to-face encounter between the AHP and the beneficiary; or

2. The HHA's face-to-face encounter form that the HHA requires the beneficiary's certifying AHP to complete as a routine business practice; or

3. Medical notes or documentation from the AHP demonstrating evidence of a face-to-face encounter within the required timeframe.

Documentation of a face-to-face encounter as detailed above must be kept in the beneficiary's record for ALL home health service related requests, including therapy services, medical equipment and supplies, and services for beneficiaries under the age of 21.

The face-to-face encounter may be conducted by one of the following practitioners:

1. The beneficiary's AHP;

2. A nurse practitioner or clinical nurse specialist working in collaboration with the beneficiary's AHP;

3. A physician assistant under the supervision of the beneficiary's AHP;

4. A certified nurse--midwife, as defined in section 1861(gg) of the Social Security Act; or

5. The attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay.

Clinical findings must be incorporated into the beneficiary's medical record.

The AHP responsible for ordering the services must:

1. Document that the face-to-face encounter which is related to the primary reason the beneficiary requires home health services, occurred within the required and specified timeframes above;

2. Identify the practitioner who conducted the encounter; and

3. Indicate the date of the face-to-face encounter.

Required Assistance to Beneficiaries

In an effort to assist beneficiaries in locating a provider to submit a prior authorization request for medically necessary home health services, the beneficiary may contact Medicaid for assistance. (See Contact/Referral Information, Appendix D).

In addition, the Bureau of Health Services Financing (BHSF) may conduct surveys with beneficiaries who have been authorized to receive extended home health services. The purpose of these surveys is to ensure that BHSF will contact the appropriate provider to determine what additional assistance may be required to ensure access to the authorized services.

Emergency Preparedness Plan

The HHA must have an emergency preparedness plan that conforms to the current Louisiana Office of Emergency Preparedness (OEP) model plan. The plan is designed to manage the consequences of declared disasters or other emergencies that disrupt the HHAs ability to provide care and treatment or threaten the lives or safety of its clients.

The HHA is responsible for obtaining a copy of the current Home Health Emergency Preparedness Model Plan from OEP (see Contact/Referral Information, Appendix D).

Additionally, per CMS, the HHA must comply with the reporting requirements of the At-risk Registry. The HHA shall update the "Louisiana At-risk Registry" or other current state-required reporting mechanism as needed or as required.

At a minimum, the HHA must have a written plan that includes:

1. The evacuation procedures for agency clients who require community assistance as well as for those with available caregivers to evacuate to another location;

2. The delivery of essential care and services to agency clients whether they are in a shelter or other locations;

3. The provisions for the management of staff, including distribution and assignment of responsibilities and functions;

4. A plan for coordinating transportation services required for evacuating agency clients to another location; and

5. A declaration that the agency will notify the client's family or caregiver if the client is evacuated to another location.

The HHA must submit the plan to the parish OEP for review. Refer to LAC 48:I.9101 for details regarding the minimum standards for HHA emergency preparedness.